



CHILDREN'S ADMINISTRATION
DIVISION OF LICENSED RESOURCES
FOSTER HOME LICENSING FILE CHECKLIST

APPLICANT # 1:				APPLICANT # 2:				HOME/AGENCY:			
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WAC	REQUIRED OF APPLICANT	APPLICANT #1 DATE	APPLICANT #2 DATE	WAC	REQUIRED OF APPLICANT	APPLICANT #1 DATE	APPLICANT #2 DATE				
0050	Application received & signed (DSHS 10-011(X))			0035	Physician's Statement (If applicable)						
0035	CAMIS Clearance (RSOLIST)			0035	Therapist's Statement (If applicable)						
0035	WASIS Clearance				Previous Corrective Actions resolved	<input type="checkbox"/> Yes <input type="checkbox"/> No					
0035	FBI Clearance				Investigations Open?	<input type="checkbox"/> Yes <input type="checkbox"/> No					
0035	Records Reviewed (Complaint History, RSOLIST, FRS)				SCOPE Training						
0035	Personal Information (Autobiography)			DISPOSITION							
0035	Three reference letters Applicant #1 Applicant #2			<input type="checkbox"/> Licensed Effective: _____ <input type="checkbox"/> Re-Licensed Effective: _____ <input type="checkbox"/> Capacity/Age Change Effective: _____ No.: _____ Age _____ Gender: _____ Admin File: <input type="checkbox"/> Yes <input type="checkbox"/> No BUS ID # _____ PROV# _____ CTRL # _____ CASE # _____ <input type="checkbox"/> Name Change of Licensed Provider Effective: _____ Office Chief Review: _____ For: _____							
0210	Driver's License										
0210	Proof of Insurance Applicant #1 Applicant #2	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No									
0345	TB Test										
0520	Attended Pre-Service										
0520	HIV/AIDS Training										
0520	CPR Adult/Infant Expires										
0520	First AID Expires										
0175	Pets Deemed Safe										
0255	Evacuation Floor Plan										
0350	Medical Policy Statement			CLOSED LICENSES							
	Policy Agreement			Effective Date _____ <input type="checkbox"/> Withdrawn <input type="checkbox"/> No Response <input type="checkbox"/> Revoked <input type="checkbox"/> Suspended <input type="checkbox"/> Denied <input type="checkbox"/> Moved <input type="checkbox"/> Undeliverable <input type="checkbox"/> Expired, No Re-Application <input type="checkbox"/> Licensee Request <input type="checkbox"/> Adoption completed <input type="checkbox"/> Changed agency or licensing type <input type="checkbox"/> Dissatisfied reason: _____ <input type="checkbox"/> Family Circumstances have changed <input type="checkbox"/> No longer interested <input type="checkbox"/> Particular child left home <input type="checkbox"/> Could not meet licensing requirements <input type="checkbox"/> DLR retains file							
	LEP Form (DSHS 15-245(X))										
0050/ 0155	Facility Checklist Completed (Signed, DSHS 10-183)										
	Fire Safety Inspection										
0320	Well Test (If applicable)										
0185	No Smoking in the Home or Car										
0350	Medication Recording System										
	Created Provider No Number: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No									
REVIEWER'S COMMENTS:								NUMBER OF EFFORTS MADE Phone calls Correspondence Other Closed Provider Number? <input type="checkbox"/> Yes <input type="checkbox"/> No			

COMPLETED BY	DATE	REVIEWED BY	DATE
SENT BACK TO LICENSOR ____ Yes ____ No	DATE	RETURNED BY LICENSOR ____ Yes ____ No	DATE